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|----------------------|--------------------------------|--------------------------------|-----------|---|---------|---------|-----------|--------|
| IPDR6702 | | NORTH CAROLINA | | | | PAGE: 1 | | |
| RUN DATE: 11/07/2004 | | IPRS CHECKWRITE SUMMARY REPORT | | | | | | |
| | | CHECKWRITE DATE: 11/09/2004 | | | | | | |
| | | FINANCIAL PAYER: NCDMM | | | | | | |
| | | | | | | | TOTAL | TOTAL |
| PROVIDER | | HIGH DENIAL | NUMBER OF | | TNC | TOTAL | CLAIMS | CLAIMS |
| NUMBER | PROVIDER NAME | BOSS | DENIALS | DESCRIPTION | DENIALS | DENIALS | FINALIZED | PAID |
| 3404901 | SMOKY MOUNTAIN H/DD/SAS | 8599 | 327 | DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. | | | | |
| | | 8505 | 15 | CLAIM DENIED DUE TO INSUFFICIE NT BUDGET | 5 | 355 | 402 | 47 |
| | | 8931 | 4 | AMTNC INELIGIBLE TO RECEIVE SE RVICES IN IPRS. | | | | |
| 3404902 | BLUE RIDGE COMM UNITY | 0 | 0 | *** NO DATA TO REPORT *** | | | | |
| | | 0 | 0 | | 0 | 0 | 0 | 0 |
| 3404904 | WESTERN HIGHLAN DS LME | 0 | 0 | *** NO DATA TO REPORT *** | | | | |
| | | 0 | 0 | | 0 | 0 | 1 | 1 |
| 3404905 | TREND COMM MENT AL HLTH CTR | 0 | 0 | *** NO DATA TO REPORT *** | | | | |
| | | 0 | 0 | | 0 | 0 | 0 | 0 |
| 3404907 | RUTHERFORD-FOLK | 0 | 0 | *** NO DATA TO REPORT *** | | | | |
| | | 0 | 0 | | 0 | 0 | 0 | 0 |
| 3404910 | PATHWAYS | 8599 | 300 | DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. | | | | |
| | | 10 | 115 | DIAGNOSIS OR SERVICE INVALID F OR CLIENT AGE. VERIFY CID, DIAGNOSIS, PROCEDURE CODE FOR | 1 | 601 | 8670 | 8065 |
| | | 8505 | 77 | CLAIM DENIED DUE TO INSUFFICIE NT BUDGET | | | | |
| 3404912 | CATAWBA COUNTYM ENTAL HEALT | 8931 | 129 | AMTNC INELIGIBLE TO RECEIVE SE RVICES IN IPRS. | | | | |
| | | 8599 | 64 | DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. | 129 | 253 | 4515 | 4262 |
| | | 8000 | 30 | NO RATE AVAILABLE ON FILE TO P RICE THIS CLAIM DETAIL | | | | |
| 3404913 | MECKLENBURG COM ENTAL HEALT | 11 | 280 | CLIENT NOT ELIGIBLE ON SERVICE DATE | | | | |
| | | 0 | 0 | | 0 | 280 | 280 | 0 |
| 3404916 | CROSSROADS BEHA VIOAL HEAL | 0 | 0 | *** NO DATA TO REPORT *** | | | | |
| | | 0 | 0 | | 0 | 0 | 13 | 13 |

| PROVIDER NUMBER | PROVIDER NAME | HIGH DENIAL EOBS | NUMBER OF DENIALS | DESCRIPTION | TNC DENIALS | TOTAL DENIALS | TOTAL CLAIMS FINALIZED | TOTAL CLAIMS PAID |
|--------------------|--------------------------------|---------------------|----------------------|--|----------------|------------------|------------------------------|-------------------------|
| 3404917 | CENTERPOINT HUM AN SERVICES | 120 | 100 | CLIENT ID NUMBER MISSING OR IN VALID. ENTER CID AND SUBMIT AS A NEW CLAIM | | | | |
| | | 21 | 24 | DUPLICATE OF CLAIM-SYSTEM | 0 | 126 | 1665 | 1539 |
| | | 8526 | 1 | CLAIM DENIED, UNITS BILLED MUS T BE GREATER THAN ZERO | | | | |
| 3404918 | ROCKINGHAM CO M ENTAL HEALT | 8599 | 45 | DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. | | | | |
| | | 8935 | 6 | ASTNC INELIGIBLE TO RECEIVE SE RVICES IN IPRS. | 7 | 62 | 706 | 644 |
| | | 5404 | 4 | SEVERE DUPLICATE: SAME ATTD PR OV/PCODE/TOS/DOS/MOD | | | | |
| 3404919 | GUILFORD CO MEN TAL HEALTHC | 8599 | 234 | DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. | | | | |
| | | 8517 | 113 | CLAIMS DENIED, SUBMITTED BEYON D FILING TIMELIMIT. JULY THROUGH APRIL DOS MUST BE SUBM | 117 | 611 | 4233 | 3622 |
| | | 8935 | 56 | ASTNC INELIGIBLE TO RECEIVE SE RVICES IN IPRS. | | | | |
| 3404920 | ALAMANCE CASWEL L AREA MH D | 8517 | 282 | CLAIMS DENIED, SUBMITTED BEYON D FILING TIMELIMIT. JULY THROUGH APRIL DOS MUST BE SUBM | | | | |
| | | 8599 | 170 | DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. | 33 | 781 | 4664 | 3883 |
| | | 8518 | 122 | CLAIM DENIED, SUBMITTED BEYOND FILING TIMELIMIT. MAY AND JUNE DOS MUST BE SUBMITTED BY | | | | |
| 3404921 | ORANGE PERSON C HATHAM AREA | 5312 | 938 | PRIOR AUTHORIZED DOLLARS EXCEE DED | | | | |
| | | 11 | 51 | CLIENT NOT ELIGIBLE ON SERVICE DATE | 19 | 1164 | 2840 | 1676 |
| | | 8599 | 47 | DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. | | | | |
| 3404922 | THE DURHAM CENT ER | 0 | 0 | *** NO DATA TO REPORT *** | | | | |
| | | 0 | 0 | | 0 | 0 | 0 | 0 |
| 3404923 | VGFW AREA AUTHO RITY | 11 | 177 | CLIENT NOT ELIGIBLE ON SERVICE DATE | | | | |
| | | 8599 | 101 | DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. | 0 | 375 | 2847 | 2472 |
| | | 8622 | 47 | 60 RESIDENTIAL LEVEL II TREATM ENT RECEIVED, PA IS REQUIRED FOR ADDITIONAL SERVICE. | | | | |

| PROVIDER NUMBER | PROVIDER NAME | HIGH DENIAL EOBS | NUMBER OF DENIALS | DESCRIPTION | TNC DENIALS | TOTAL DENIALS | TOTAL CLAIMS FINALIZED | TOTAL CLAIMS PAID |
|--------------------|--------------------------------|---------------------|----------------------|--|----------------|------------------|------------------------------|-------------------------|
| 3404925 | SANDHILLS CENTE R FOR MH/DD | 21 | 2115 | DUPLICATE OF CLAIM-SYSTEM | | | | |
| | | 8517 | 316 | CLAIMS DENIED, SUBMITTED BEYON D FILING TIMELIMIT. JULY THROUGH APRIL DOS MUST BE SUBM | 11 | 2814 | 3167 | 353 |
| | | 8599 | 115 | DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. | | | | |
| 3404926 | SOUTHEASTERN RE G MENTAL HL | 8599 | 71 | DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. | | | | |
| | | 8931 | 53 | AMTNC INELIGIBLE TO RECEIVE SE RVICES IN IPRS. | 76 | 281 | 3122 | 2841 |
| | | 120 | 24 | CLIENT ID NUMBER MISSING OR IN VALID. ENTER CID AND SUBMIT AS A NEW CLAIM | | | | |
| 3404927 | CUMBERLAND CO M HC | 8505 | 1327 | CLAIM DENIED DUE TO INSUFFICIE NT BUDGET | | | | |
| | | 8599 | 182 | DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. | 0 | 1645 | 3771 | 2126 |
| | | 8517 | 39 | CLAIMS DENIED, SUBMITTED BEYON D FILING TIMELIMIT. JULY THROUGH APRIL DOS MUST BE SUBM | | | | |
| 3404929 | LEE HARNETT MH/ DD/SAS | 21 | 75 | DUPLICATE OF CLAIM-SYSTEM | | | | |
| | | 8599 | 16 | DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. | 0 | 111 | 3572 | 3461 |
| | | 143 | 6 | CLIENT ID NUMBER NOT ON STATE ELIGIBILITY FILE | | | | |
| 3404930 | JOHNSTON COUNTY MNTL HLTHC | 0 | 0 | *** NO DATA TO REPORT *** | | | | |
| | | 0 | 0 | | 0 | 0 | 0 | 0 |
| 3404931 | WAKE CO HUM SVC BILLING OF | 8599 | 368 | DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. | | | | |
| | | 120 | 163 | CLIENT ID NUMBER MISSING OR IN VALID. ENTER CID AND SUBMIT AS A NEW CLAIM | 265 | 1022 | 4424 | 3402 |
| | | 8935 | 160 | ASTNC INELIGIBLE TO RECEIVE SE RVICES IN IPRS. | | | | |
| 3404932 | RANDOLPH/SANDHI LLS CO MH C | 0 | 0 | *** NO DATA TO REPORT *** | | | | |
| | | 0 | 0 | | 0 | 0 | 0 | 0 |
| 3404933 | SOUTHEASTERN CT R FOR MH/DD | 8599 | 89 | DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. | | | | |
| | | 8000 | 88 | NO RATE AVAILABLE ON FILE TO P RICE THIS CLAIM DETAIL | 25 | 259 | 2420 | 2161 |
| | | 8931 | 18 | AMTNC INELIGIBLE TO RECEIVE SE RVICES IN IPRS. | | | | |

| PROVIDER NUMBER | PROVIDER NAME | HIGH DENIAL EOBS | NUMBER OF DENIALS | DESCRIPTION | TNC DENIALS | TOTAL DENIALS | TOTAL CLAIMS FINALIZED | TOTAL CLAIMS PAID |
|--------------------|---------------------------------|---------------------|----------------------|--|----------------|------------------|------------------------------|-------------------------|
| 3404934 | ONSLow COUNTY B BEHAVIORAL H | 11 | 15 | CLIENT NOT ELIGIBLE ON SERVICE DATE | | | | |
| | | 8599 | 8 | DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. | 0 | 30 | 216 | 186 |
| | | 8517 | 3 | CLAIMS DENIED, SUBMITTED BEYON D FILING TIMELIMIT. JULY THROUGH APRIL DOS MUST BE SUBM | | | | |
| 3404935 | WAYNE CO MENTAL HEALTH CTR | 0 | 0 | *** NO DATA TO REPORT *** | | | | |
| | | 0 | 0 | | 0 | 0 | 0 | 0 |
| 3404936 | WILSON-GREENE M ENTAL HEALT | 21 | 32 | DUPLICATE OF CLAIM-SYSTEM | | | | |
| | | 120 | 8 | CLIENT ID NUMBER MISSING OR IN VALID. ENTER CID AND SUBMIT AS A NEW CLAIM | 8 | 73 | 829 | 756 |
| | | 5404 | 8 | SEVERE DUPLICATE: SAME ATTD PR OV/PCODE/TOS/DOS/MD | | | | |
| 3404937 | EDGEcombe NASH MNTL HLTH C | 8517 | 122 | CLAIMS DENIED, SUBMITTED BEYON D FILING TIMELIMIT. JULY THROUGH APRIL DOS MUST BE SUBM | | | | |
| | | 21 | 31 | DUPLICATE OF CLAIM-SYSTEM | 4 | 213 | 2574 | 2361 |
| | | 8000 | 15 | NO RATE AVAILABLE ON FILE TO P RICE THIS CLAIM DETAIL | | | | |
| 3404938 | VGFW DBA RIVERS TONE COUNSE | 8599 | 62 | DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. | | | | |
| | | 8000 | 31 | NO RATE AVAILABLE ON FILE TO P RICE THIS CLAIM DETAIL | 9 | 177 | 1763 | 1586 |
| | | 21 | 30 | DUPLICATE OF CLAIM-SYSTEM | | | | |
| 3404939 | NEUSE MENTAL HE ALTH CENTER | 8517 | 1 | CLAIMS DENIED, SUBMITTED BEYON D FILING TIMELIMIT. JULY THROUGH APRIL DOS MUST BE SUBM | | | | |
| | | 0 | 0 | | 0 | 1 | 139 | 138 |
| 3404941 | PITT CO MH/DD/S AS CENTER | 11 | 368 | CLIENT NOT ELIGIBLE ON SERVICE DATE | | | | |
| | | 8599 | 173 | DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. | 26 | 776 | 1746 | 970 |
| | | 21 | 114 | DUPLICATE OF CLAIM-SYSTEM | | | | |
| 3404942 | ROANoke CHOWANH UMAN SERVIC | 8599 | 38 | DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. | | | | |
| | | 21 | 10 | DUPLICATE OF CLAIM-SYSTEM | 9 | 63 | 1499 | 1436 |
| | | 8935 | 5 | ASTNC INELIGIBLE TO RECEIVE SE RVICES IN IPRS. | | | | |

| PROVIDER | | HIGH DENIAL | NUMBER OF | | TNC | TOTAL | TOTAL | TOTAL |
|----------|---|-------------|-----------|--|---------|---------|-----------|-------|
| NUMBER | PROVIDER NAME | EOBS | DENIALS | DESCRIPTION | DENIALS | DENIALS | FINALIZED | PAID |
| 3404943 | ALBEMARLE MENTAL HEALTH CE | 191 | 35 | CLIENT ID NUMBER DOES NOT MATCH PATIENT NAME | | | | |
| | | 8518 | 22 | CLAIM DENIED, SUBMITTED BEYOND FILING TIMELIMIT. MAY AND JUNE DOS MUST BE SUBMITTED BY | 25 | 177 | 1942 | 1765 |
| | | 21 | 22 | DUPLICATE OF CLAIM-SYSTEM | | | | |
| 3404944 | EASTPOINTE HUMAN SERVICES | 8599 | 26 | DETAIL NOT COVERED BY COMBINATION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. | | | | |
| | | 8931 | 19 | AMTNC INELIGIBLE TO RECEIVE SERVICES IN IPRS. | 31 | 102 | 1842 | 1740 |
| | | 8518 | 14 | CLAIM DENIED, SUBMITTED BEYOND FILING TIMELIMIT. MAY AND JUNE DOS MUST BE SUBMITTED BY | | | | |
| 3404946 | FOOTHILLS AREA MENTAL HEALTH | 8599 | 421 | DETAIL NOT COVERED BY COMBINATION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. | | | | |
| | | 11 | 417 | CLIENT NOT ELIGIBLE ON SERVICE DATE | 5 | 948 | 5154 | 4206 |
| | | 191 | 93 | CLIENT ID NUMBER DOES NOT MATCH PATIENT NAME | | | | |
| 3404957 | TIDELAND MENTAL HEALTH CTR | 8518 | 27 | CLAIM DENIED, SUBMITTED BEYOND FILING TIMELIMIT. MAY AND JUNE DOS MUST BE SUBMITTED BY | | | | |
| | | 537 | 21 | PROCEDURE IS NOT COVERED FOR THIS DATE OF SERVICE | 27 | 115 | 391 | 276 |
| | | 21 | 15 | DUPLICATE OF CLAIM-SYSTEM | | | | |
| 3404959 | DAVIDSON COMMUNITY MENTAL HEALTH CENTER | 0 | 0 | *** NO DATA TO REPORT *** | | | | |
| | | 0 | 0 | | 0 | 0 | 0 | 0 |
| 3404979 | NEW RIVER AREA MENTAL HEALTH/SAFETY PROGRAM | 8931 | 45 | AMTNC INELIGIBLE TO RECEIVE SERVICES IN IPRS. | | | | |
| | | 8599 | 16 | DETAIL NOT COVERED BY COMBINATION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. | 48 | 68 | 1827 | 1759 |
| | | 8935 | 3 | AMTNC INELIGIBLE TO RECEIVE SERVICES IN IPRS. | | | | |